STRATEGIES TO INCREASE ENROLLMENT IN CHILDREN'S HEALTH INSURANCE PROGRAMS: A REPORT OF THE NEW YORK ACADEMY OF MEDICINE

DENNIS P. ANDRULIS, PHD, TAMAR A. BAUER, JD, AND SARAH HOPKINS, MPA

OVERVIEW

Publicly subsidized health insurance programs are available for millions of children nationwide, yet many eligible children remain uninsured. Research has shown that:

- Nationwide, 4.7 million children 18 years and under are eligible for, but not enrolled in, Medicaid.
- Over 770,000 New York State children (approximately 15%) are uninsured.
- Among uninsured children in New York State, 37% are estimated to be Medicaid eligible, and in 1999, an estimated 27% will be eligible for Child Health Plus.
- Nearly three-quarters of uninsured children in New York City are eligible for, but not enrolled in, Medicaid or Child Health Plus.

While coverage alone does not guarantee access to health care, uninsured children are more likely than insured children to have health problems, experience difficulty obtaining needed care, rely on emergency care, underuse preventive care, and face difficulties paying medical bills. Studies have also shown that uninsured children are more likely to experience restrictions on childhood activities such as rollerblading, bike riding, or team sports because of parental concerns about possible accidents and attendant medical care costs, as well as regulations governing school sports programs. Improving access to health insurance helps reduce such disparities.

New York State is on the brink of an unprecedented expansion in health insurance outreach for children in low-income families. Significant outreach funds newly available to New York communities will be distributed by the New York State Department of Health through a Request for Proposals that will be issued in spring 1999. This article identifies noteworthy strategies from New York State and communities nationwide for enrolling

---

Drs. Andrulis and Bauer and Ms. Hopkins are from the Office of Urban Health Populations, New York Academy of Medicine.

Correspondence: Dennis Andrulis, PhD, Head, Office of Urban Health Populations, New York Academy of Medicine, 1216 Fifth Avenue, New York, NY 10029. (E-mail: dandrulis@pop3.nyam.org)

children into Medicaid and separate state programs like Child Health Plus, considering in particular their applicability to New York State. It is written in the context of an invigorated public and private commitment to enroll eligible but uninsured children, which corresponds with recent federal and state laws that expand health coverage opportunities for children.

Effective April 15, 1998, New York State began receiving $256 million in annual Title XXI funding under the federal State Children's Health Insurance Program, with nearly $2.6 billion expected over the next 10 years, to provide health insurance for children currently ineligible for Medicaid. The federal funding augments state support for the Child Health Plus program, which increased from $82 million in 1996 to $207 million in 1999. As a result of recent state legislation, subsidized health insurance under Child Health Plus became available on January 1, 1999, to families with gross incomes up to 230% of the federal poverty level, or $37,901 annually for a family of four. Effective July 1, 2000, eligibility will be expanded to families with gross incomes up to 250% of the federal poverty level, or $41,059 annually for a family of four.

To reach new and previously eligible but uninsured children, the nature and definition of outreach are undergoing a transformation. Efforts are shifting away from traditional methods, such as distributing fliers and media campaigns, and toward more targeted activities that facilitate individual enrollment. New federal, state, and private funds will support outreach opportunities that extend far beyond New York's previous experience. Current and enhanced enrollment objectives, while challenging, may be met through collaboration, innovation and building on past successes. The following are examples of outreach, marketing, and enrollment strategies cited in the guide that can be duplicated and expanded to meet enhanced enrollment objectives:

Providing assistance in completing application forms through community-based organizations, hospitals, employers, and schools.

A Yonkers public school runs a Family Resource Center, which is staffed by parent aides who are paid by Kraft Foods. The center provides assistance and referral services on a range of issues, including Medicaid and Child Health Plus. Aides offer parents classes in English as a second language and computer instruction and even accompany parents to welfare offices to advocate on their behalf. Immigrants may require specific outreach attention to address concerns they may have about reporting to the Immigration and Naturalization Service and a general distrust of government programs.

Linking public health insurance with other public programs, including the Women, Infants, and Children (WIC) supplemental nutrition food program; food stamps; school lunch; Head Start; Temporary Assistance to Needy Families; the foster care system; Department of Motor Vehicles; and voter registration.

Florida's Healthy Start Program links eligibility for Medicaid to eligibility for the school lunch program. A Chicago public school system is piloting a program that allows sharing of eligibility data between the school lunch program and Medicaid. In Missouri, children in foster care are specially linked with Medicaid; when children are registered initially with a foster care agency, they are screened and enrolled for Medicaid automatically if they are found eligible.

Simplifying the application form by allowing mail-in application forms, shortening the application, combining application forms for Medicaid and separate state programs, and translating materials into languages other than English.

Long and confusing application forms pose formidable barriers to enrollment. The Medicaid application form has been shortened in 29 states to be the same length or shorter than the Health Care Financing Administration's model application. Simplifying the application form

can reduce barriers to enrollment, which may result in better health outcomes. Georgia shortened its application form in 1993 and saw a 42% increase in enrollment among pregnant women and children, which lowered infant mortality and raised immunization rates. New York currently is piloting a combined Medicaid/WIC/Child Health Plus application in select sites statewide.

Streamlining enrollment and recertification by outstationing eligibility workers in nontraditional settings during nonbusiness hours, delegating nongovernmental workers to conduct the Medicaid interview, and improving the recertification process to ensure that children not only enroll in insurance, but also continue to have insurance as long as they are eligible.

Allowing nongovernmental workers to conduct the Medicaid interview is an important strategy to enhance access to Medicaid and reduce the potential stigma and burden of a visit to the Medicaid office. The New York City Human Resources Administration, the local agency responsible for Medicaid eligibility, authorizes Mount Sinai Hospital's Resource Entitlement Advocacy Program (REAP) to conduct the face-to-face Medicaid interview. REAP also assists applicants and recipients in assembling the necessary documentation and submits the application package to the Human Resources Administration for eligibility determination. REAP has a 99.9% Medicaid application approval rate, and the Health Care Financing Administration has identified it as a model outreach program.

While New York State has made progress in broad-based outreach and marketing efforts, facilitated enrollment activities are the highest priority for future growth. New programs with day-care centers, schools, and WIC sites offer promise. For the first time in decades, New York has the opportunity to provide near-universal coverage for low-income children. New federal and state laws authorize streamlined access to Medicaid and Child Health Plus, provide needed resources for innovative outreach, and demonstrate strong political support for enrolling eligible children. Communities around the country have showcased outreach initiatives that can be replicated and revised to meet the needs of other regions. Promising local strategies may be particularly relevant for New York State, long a leader in children's health insurance.

At the same time, the strong currents driving welfare reform present a challenge to the State Children's Health Insurance Program enrollment mandate. In many states, families are subject to conflicting messages: while they are discouraged from applying for cash assistance, they are encouraged to apply for children's health insurance. Eligibility workers driven by these potentially conflicting objectives may find it difficult to increase Medicaid enrollment for children. Given the universal commitment at the federal, state, and local levels to enroll uninsured children, the rationale for any conflicting initiatives should be revisited.

New York State's long-standing commitment to the health of its low-income children was reaffirmed most recently in the 1998 legislative expansion of Medic-

aid and Child Health Plus. Realizing the opportunities created by the law, and providing health insurance for all children who are eligible, will require the cooperation and collaboration of many. This article is offered in support of those efforts.

INTRODUCTION

Nationwide, an estimated 4.7 million children 18 years and under are eligible but not enrolled in Medicaid.[1] Of the 771,200 uninsured children in New York State, more than 37% are estimated to be Medicaid eligible,[2] and in 1999 an estimated 27% will be eligible for, but not enrolled in, Child Health Plus.[3] While enrollment in Child Health Plus rose dramatically from 140,000 in July 1997 to almost 240,000 in September 1998, there has been a decline in the number of children enrolled in Medicaid since 1995. Although coverage alone does not guarantee access to health care, uninsured children are more likely than insured children to have problems obtaining needed care, rely on emergency care, underuse preventive care, have health problems, and experience difficulties paying medical bills.[4,5] Studies have also shown that uninsured children are more likely to experience restrictions on childhood activities such as rollerblading, bike riding, or team sports because of parental concerns about possible accidents and attendant medical care costs, as well as regulations governing school sports programs.[6]

In response to the increasing numbers of uninsured children nationwide, the federal government created the State Children's Health Insurance Program (SCHIP), the 10-year, $50 billion federal package enacted in 1997 as Title XXI of the Social Security Act. Effective April 15, 1998, New York State began receiving $256 million in annual federal funding, with nearly $2.6 billion expected over the next 10 years, to provide health insurance for children currently ineligible for Medicaid. The federal funding augments state support for the Child Health Plus program, which increased from $82 million in 1996 to $207 million in 1999. Of the combined federal and state allocation to the program, 10% may be spent on administration, outreach, and direct services. Additional federal funds for outreach are available at a 90% federal match under Medicaid. Finally, up to $1 million over 3 years may become available for outreach in New York through the Covering Kids initiative of the Robert Wood Johnson Foundation. Other foundations supporting related projects include the Commonwealth Fund, David and Lucile Packard Foundation, Ford Foundation, Foundation for Child Development, Henry J. Kaiser Family Foundation, New York Community Trust, and United Hospital Fund of New York.

The purpose of this article is to assist in planning outreach strategies within the context of this changed environment, especially within New York State. Its focus on access to coverage is part of the mission of the New York Forum for Child Health, a multidisciplinary effort created to improve the health of children within the state. While presenting a synopsis of the outreach context within New York State, as well as selected research, its primary content describes enrollment, marketing, and outreach strategies taking place in the state and across the country. In so doing, it both offers innovative strategies for consideration by policymakers and providers and places selective New York State initiatives in the context of other states' activities to reach eligible children.

BACKGROUND

On September 24, 1998, Governor George Pataki signed into law an expansion of children's health insurance in New York State. The expansion does the following:

- raises income eligibility levels for both Medicaid and Child Health Plus;
- increases Child Health Plus benefits to include emergency, preventive, and routine dental care, except orthodontia and cosmetic surgery; emergency, preventive, and routine vision care, including eyeglasses; speech and hearing services; durable medical equipment; nonprescription drugs; outpatient mental health services and inpatient mental health, alcohol, and substance abuse services;
- eliminates Child Health Plus premiums for some families and copayments for all families;
- provides for a joint Medicaid/Child Health Plus application (currently being piloted in select areas around New York State);
- establishes presumptive eligibility and 12-month continuous eligibility for Medicaid;
- requires community-based public education, outreach, and enrollment for both programs;[1] and
- stipulates the outstationing of authorized workers to help families complete the application enrollment process in geographically accessible community settings during nonbusiness hours.[7]

The expansion has been lauded as an important step toward reducing the number of uninsured children statewide and improving their health coverage. The New York State Department of Health plans to issue a Request for Proposals in spring 1999 to distribute the outreach funds available to New York communities. New funds will support outreach opportunities that extend far beyond New

York's previous experience. In addition, the legislative provisions regarding outreach and enrollment outline a significantly streamlined process for families to access both programs.

Enrolling hundreds of thousands of uninsured but eligible children will require multilevel and coordinated strategies. Traditional efforts such as media campaigns, flier distribution, and hot lines will be an important first step in raising awareness. Under the new federal and state laws, however, the objective is to reach families not simply to inform them that programs exist, but also to provide individual assistance with the application process and to facilitate enrollment when authorized. Programs offering such assistance already exist in most states, but they have limited capacity. In this article, model programs are identified for replication and expansion purposes.

Coordination among organizations responsible for outreach and enrollment will also be critical. For example, an organization that distributes fliers and provides speakers for community meetings about the programs can funnel applicants to an agency that provides assistance with applications, which in turn can link with an organization with the authority to enroll children. Ideally, some agencies will have the capacity to conduct the full range of outreach and facilitated enrollment. Organizations will need to consider staffing and training issues in assessing their capacity to undertake enhanced outreach activities.

Many barriers to enrolling in child health insurance programs are well known. Research has shown that eligible children are not enrolled in publicly subsidized insurance programs because their parents lack the knowledge that the programs exist or do not know that their children are eligible. Some research has indicated that Medicaid is associated with feelings of shame,[8,9] although it is not clear if embarrassment or stigma would continue if the Medicaid enrollment process was improved. The foreign born, who are disproportionately eligible but uninsured,[10] may be more likely to fear government programs than the native born due to fears of being reported to the Immigration and Naturalization Service, encountering future difficulty in obtaining citizenship, or facing deportation. Other barriers include a general perception that the application process is burdensome and that applying will entail long waits and confusing paperwork.[8]

Recent changes in welfare and immigration laws pose additional barriers to families seeking health insurance for their children.[9,11] In New York and most other states today, families are subject to conflicting messages: while they may be discouraged from applying for cash assistance, federal and local governments are trying to bring children from those same families onto the Medicaid rolls. Eligibility workers driven by these conflicting objectives may find it challenging

to increase enrollment for children.[12,13] Furthermore, county concerns about their share of Medicaid costs may limit the scope of local efforts to improve access to Medicaid. Designing outreach and enrollment strategies to address both the traditional and more recent impediments is likely to be more effective in increasing enrollment of eligible children.

INNOVATIVE OUTREACH, MARKETING, AND APPLICATION ASSISTANCE

The following section outlines innovative outreach, marketing, and application assistance strategies, ranging from those that reach the broadest population, such as media campaigns, to those that target specific populations, such as students or members of congregations. While New York has made significant progress in outreach and marketing to date, the highest priority for future growth concerns facilitated enrollment activities, discussed in the section below on improving the application form.

Outreach and marketing strategies may include television or radio advertisements or information distribution through schools or the workplace. *Application assistance* refers to programs that help families with the paperwork necessary to apply or recertify. Outreach strategies that include application assistance are likely to be more effective in meeting current enrollment objectives than strategies that rely only on media campaigns and distribution of fliers.

At least two barriers to enrollment identified in the research literature can be overcome through outreach and marketing efforts: lack of knowledge and, to a limited degree, stigma. While parents often know that Medicaid exists, they may not know that their children are eligible. Children of working parents, those living in two-parent families, and those whose parents are foreign born are disproportionately uninsured,[10] in part due to a misconception among parents that their work, marital, or nativity status causes their children to be ineligible. Parents are generally less knowledgeable about the Child Health Plus program. The stigma sometimes associated with Medicaid may also pose a significant barrier. Outreach efforts that unlink the public image of Medicaid and cash assistance, and that focus on the value of the Medicaid benefit, may encourage families to apply.

Additional barriers, including perceptions of confusing paperwork and a tedious application process, can be overcome with application assistance. Conversations with families and staff at community organizations reveal the importance of personal assistance in guiding families through the application process. Applications in some states are as long as 30 pages and require extensive supporting

documentation that may be difficult for families to gather. Families receiving assistance with the application may be more likely to complete the application or recertification successfully.

Broad-Based Efforts

The following strategies reach out to broad segments of the public through non–health care settings.

On radio and television. The Health Care Financing Administration (HCFA), the American Hospital Association, the March of Dimes, and a Washington, D.C., television station have introduced a television campaign to advertise child health insurance programs in Maryland and Washington, D.C. The ads are featured on "Oprah," "ABC Nightline," and "Wheel of Fortune."[14] Viewers are directed to call a toll-free number for application information. Rhode Island airs advertisements for RIteCare on radio stations that broadcast in languages other than English. Interviews with RIteCare administrators note that advertising on these stations is cheaper than advertising on stations that broadcast in English. RIteCare used public service announcements, but has found that stations are only likely to air them if they are timed with an event such as the passage of legislation or a health fair. Colorado's Child Health Plan Program purchases radio and television time to advertise its program and asks that the stations match the purchase with free public service announcements, which may be a more effective way to convince stations to air the announcements.[15] Georgia's PeachCare for Kids program airs an interview with an outreach worker on local gospel radio stations.

On the roadway. Georgia's Medicaid program incorporates outreach efforts at highway roadblocks to ensure that children are buckled properly in car safety seats. At these roadblocks, Medicaid outreach workers distribute Medicaid brochures and a number to call to receive assistance in applying.[15]

At restaurants and shopping areas. Colorado uses libraries, malls, supermarkets, and shopping centers as venues for recruitment into programs. Georgia distributes flyers in pizza delivery boxes and in children's shoe boxes. Fast-food restaurants in Maryland advertise on tray liners.[16]

Targeted Strategies

The following strategies target parents or children where they tend to congregate and are aimed at specific populations that are more likely to be eligible and uninsured. Possible venues listed below include public benefits programs, early childhood centers, schools, hospitals, employment settings, and religious institutions.

Other public benefits programs. Many states have linked the Women, Infants, and Children (WIC) supplemental food program with Medicaid. Alabama child program staff noted in interviews that their state uses its WIC program to advertise Medicaid and ALKids through its monthly newsletter and on WIC vouchers. Rhode Island plans to include RIteCare promotional materials with unemployment checks.[17] North Carolina Division of Medicaid Assistance staff indicated that they intend to enclose information on its programs in utility bills.

Early childhood centers. Kansas and Virginia have established home visitation programs to reach out to parents of infants and toddlers who may be eligible for Medicaid.[18] Kentucky reaches out to parents of infants and toddlers through First Steps, a combined effort of the Medicaid and Maternal and Child Health agencies.[18] Wisconsin has a program similar to Kentucky's, called Birth to Three.

Schools. Many states make literature available to parents through schools. Florida is a leader in the area, with extensive outreach that includes activities at school fairs and linkage of eligibility for Healthy Kids through the school lunch program.[19] Other examples include Utah, which distributes flyers on its program to parents at back-to-school nights and to students eligible for reduced-price school lunch programs.[2] Rhode Island conducts a targeted mailing to parents. Alabama includes a Medicaid/ALKids application kit with school registration information at the beginning of the school year. The kit contains a postage-paid envelope in which parents may return the completed application.

In hospitals. The American Hospital Association's Campaign for Coverage has profiled the successes of many hospitals throughout the country in enrolling children into health insurance programs. Among them are the Hutzel Hospital in Detroit, Michigan, which employs hospital staff to send letters to Medicaid applicants who have not completed their Medicaid applications.[20] Grady Hospital in Atlanta, Georgia, stations six paid hospital staff and several Spanish-speaking volunteers to assist patients in applying for Medicaid, food stamps, and WIC.[20] Grady Hospital has experienced a surge in Medicaid enrollment among pregnant women, and the average length of the application process has decreased from 45 to 30 days. A hospital in Greenville, South Carolina, has installed a computerized system that allows outstationed Medicaid workers to access the state Medicaid eligibility database from the hospital intake unit. The hospital also streamlines its case management system to allow pregnant women to receive services and entitlement assistance in one location, through one visit, and coordinates with the local housing authority, churches, and social services agencies to identify

pregnant women in need of care. Application completion, approval rate, and birth outcomes at this hospital have all improved substantially. Parkland Hospital in Dallas, Texas, formally trains its physicians and nurses on Medicaid eligibility and the application process. Parkland has seen an increase in prenatal care utilization rates and a decrease in emergency room usage.[20]

Through employers. The Philadelphia Citizens for Children, the Youth's Child Watch Project, and the Southwest Belmont Community Association organize 150 small businesses to conduct outreach about child health insurance programs.[21] The California Small Business Association and the Children's Partnership have collaborated to conduct outreach to employees of small businesses, who are more likely to be uninsured.[10] The business association and the Children's Partnership help employers in assisting employees with the application process, particularly in providing documentation of wages and income. Their literature emphasizes that helping employees enroll their children in health insurance increases work productivity, decreases absenteeism, and addresses concerns about "crowd out." (*Crowd out* refers to the possibility that employees will drop private health insurance in favor of public coverage.)

Georgia's Right From the Start Medicaid conducts outreach and application assistance in fast-food chains, factories, and Wal-Mart discount department stores. They have found factory cafeterias to be convenient venues for reaching employees. Right From the Start comes to a cafeteria during each factory shift and informs employees about Medicaid and helps them apply. According to a Right From the Start Medicaid administrator, fast-food chains have less room and fewer employees to conduct outreach during any one shift. Instead, they post information on Medicaid in fast-food chains where employees can see it, such as near the time clock or on pay stubs. Right From the Start has found it important to cultivate a relationship with local businesses to ensure that they can enter the workplace repeatedly for outreach efforts. Georgia plans to conduct similar outreach strategies with PeachCare for Kids.

Colorado health officials plan to target working class parents, particularly those in the service industry and in small businesses, through collaboration with the Colorado Association of Commerce and Industry and the Colorado Forum.[22]

In religious institutions. Georgia's Right From the Start Medicaid and PeachCare programs conduct outreach and outstationing in large urban churches. They also bring mobile medical units to provide medical care to parishioners throughout the week. North Carolina is attempting to involve its Council of Churches in its outreach plan.

Focusing on vulnerable populations and those typically uninsured. Arkansas and Massachusetts target their campaigns specifically at working parents who are particularly likely to have uninsured and eligible children. The Center on Budget and Policy Priorities sponsors the Start Healthy/Stay Healthy campaign targeting working parents. Their promotional materials in English and Spanish include a poster emphasizing children's eligibility for SCHIP and Medicaid regardless of their parents' work status or receipt of welfare.

According to the US General Accounting Office (GAO), few states specifically design their programs to meet the needs of immigrants and minorities.[10] Some efforts include a Massachusetts organization, which adapts its outreach efforts to the needs of seasonal workers, who are often migrant workers and eligible for benefits. During the summer, Massachusetts focuses outreach activities in resort communities where seasonal workers live.[15] The Midwest Migrant Health Information office reaches out to migrant workers in eight states through trained health promoters.[15] The office pays bilingual health promoters a small stipend and provides them with instruction on providing health education and referrals. Rhode Island is also making a special effort to reach out to immigrants by developing a question-and-answer sheet on RIteCare targeted to community-based organizations serving immigrants. Florida markets its programs so that they are easy to understand; materials on Healthy Kids are written at the fifth-grade reading level. California plans to market Healthy Kids in the Spanish language media.[23]

Outreach, Marketing, and Application Assistance in New York State

The following are select examples of outreach, marketing, and application assistance efforts in New York State. Included are activities conducted through health centers, coalitions, community-based organizations, public-private partnerships, advertisements, and hot lines. Activities organized and funded by the state are also included, as are efforts by managed-care plans that have invested significant effort in outreach for Child Health Plus to date.

At health centers. The Peekskill Area Health Center provides stipends to trained community members who provide health education and outreach to difficult-to-reach populations.[24] In Yates County, the Rushville Health Center provides assistance in enrolling children into Medicaid and Child Health Plus through a team consisting of an outreach worker and a public health nurse. Steuben, Allegheny, and Yates Counties have based an application to the Robert Wood Johnson Foundation's Covering Kids Initiative on the Rushville model.

At schools. A Yonkers public school runs a Family Resource Center, which is staffed by parent aides who are paid by Kraft Foods. The center provides assistance and referral services on a range of issues, including Medicaid and Child Health Plus. Aides offer parents classes in English as a second language, computer instruction, and even accompany parents to welfare offices to advocate on their behalf.

Through coalitions. The Rochester Children's Collaborative broadly distributes literature on Medicaid and Child Health Plus to parents of school-age children, day-care centers, health and immunization clinics, laundromats, employment agencies, churches, cable access stations, and family court waiting areas. The collaborative also distributes enrollment kits and balloons at Wal-Mart and at a local lumberjack festival. The collaborative finds the festival a more effective venue than traditional health fairs because the literature stands out as the only health-related material.

At community-based organizations. In Brooklyn, New York City, the Caribbean Women's Health Association (CWHA) provides application and recertification assistance to its clients. CWHA clients, many of whom are foreign born and have limited access to social services, receive assistance from a CWHA outreach worker throughout the application or recertification process, including the assembling of necessary documentation. CWHA offers its services at its center in Brooklyn and reaches out to the community through churches. Programs like CWHA are particularly important for foreign-born parents, who may feel safer applying for insurance at a community center rather than at a Medicaid office, which may be intimidating, may not be staffed with translators, and may be farther away.

The Medical and Health Research Association of New York City recently received funding from the Commonwealth Fund to operate a 1-year service demonstration project in South Brooklyn to conduct individual education and application assistance to WIC beneficiaries and employees of small businesses, including WIC vendors.

Homeless children, a particularly vulnerable population with poor access to social services, are not likely to be reached through traditional locations. An administrator at Care for the Homeless in New York City suggests reaching children at homeless shelters by training shelter staff to inform parents about the programs and assist them in assembling documents and completing applications.

Through managed-care plans. Plans offering Child Health Plus have developed marketing, outreach, and enrollment strategies that include expanded office hours, language-appropriate staff, participation in community events and holi-

days important to targeted populations, and educational conferences for community-based organizations in their service area. For example, HealthPlus, a plan in Southwest Brooklyn, experienced substantial growth through hiring enrollment staff reflecting the Hispanic, Chinese, Arabic, African-American, and Russian communities. HealthSource, a managed-care plan in Westchester County, works with churches on community projects, including clothing drives, to establish trust with immigrants they seek to enroll. Most managed-care plans report working with schools in their area to identify eligible children and follow up with applications when possible. HIP of Greater New York sends invitations home with students for parents to attend massive open houses for Child Health Plus, where application assistance is provided for parents in community centers on weekends. BlueCross/BlueShield plans send information on Child Health Plus to subscribers who cancel individual policies. The Bronx Health Plan makes an effort to help recipients stay enrolled by assisting them with the recertification process. Three months before a client's coverage expires, the plan sends colorful notices. After repeated mailings, marketing representatives call recipients at night and on weekends to alert them to the need to recertify. While most parents who are reached by phone successfully recertify, many are not reached.

Through public-private partnerships. The New York State Department of Health subcontracts with private organizations to conduct outreach activities that supplement the state's efforts. From 1991 to 1996, the department contracted with the Public Policy Education Fund to coordinate promotional activities outside New York City and with the Medical and Health Research Association for New York City–based outreach efforts. The HMO Council of New York was awarded the outreach contract in 1997–1998 and subcontracted with perinatal health networks statewide to promote the program and facilitate enrollment.

In New York State courts, the Permanent Judicial Commission on Justice for Children runs children's centers that mainly serve children in foster care.[24] Parents can leave their children at the children's centers while they are in court, and when they pick up their children, staff provide parents with information about Child Health Plus and Medicaid and attempt to assist them in the application process when possible. Two-thirds of the children who frequent the children's centers are on public assistance, many are Medicaid eligible, and most are not in formal early childhood centers such as Head Start or preschool.[24] Outreach with this population is considered to be particularly difficult because the families are often in crisis, and health insurance is not a priority when they are dealing with the family court system.[24]

Through advertisements. New York State's Child Health Plus program materials target different age groups and ethnicities. In its Web site, subway ads, and program brochures, the children portrayed range in age up to adolescence and are of diverse backgrounds. New York City features new subway ads for Medicaid managed care that display varying age groups and ethnicities. The State Department of Health Web site displays the Child Health Plus brochure, a downloadable request form for Child Health Plus promotional materials, and information for providers on the program's budget.

Information and referral hot lines. Hot lines are an important information resource for families interested in applying for Medicaid or Child Health Plus. New York operates two statewide, toll-free hot lines. The Growing Up Healthy hot line dispenses information on Child Health Plus, early intervention programs, Haemophilus influenzae type B disease, immunizations, infant health assessment, Prenatal Care Assistance Program, sudden infant death syndrome, teen pregnancy, and WIC. Child Health Plus operates a statewide hot line, and each Child Health Plus plan has its own toll-free number for information about its plan. To obtain information on Medicaid through a hot line, New Yorkers must call a hot line specific to their local area. In an effort to assess these hot lines, New York Forum for Child Health staff called each hot line several times and requested information on Medicaid and Child Health Plus.

The Growing Up Healthy hot line had little to no waiting time and asked callers how they heard of the program, which is an effective evaluation tool. Staff provided advice on how to choose a plan, were friendly and informative, and made information available in Spanish. Callers asking about health insurance for children were informed of Child Health Plus; however, information on Medicaid was not offered unless specifically requested. Hot line workers referred callers to their local Medicaid hot line if callers inquired about Medicaid.

Like Growing Up Healthy, the Child Health Plus hot line had little to no waiting time. Hot line workers read callers an alphabetized list of participating insurers in their region, but did not provide advice on how to choose a plan. The Child Health Plus hot line employs Spanish-speaking operators during certain hours.

New York City's local Medicaid hot line is a Human Resources Administration number that supplies information on a broad range of programs, including Medicaid, through an automated system. While centralizing information on many benefits programs on one number seems ideal, the automated system has so many options that it is difficult for callers to know which button to press. Further-

more, the system uses confusing language, referring to "HRA" and "benefits" rather than "Medicaid." To receive a Medicaid application, callers must navigate their way through numerous options. Waiting times can be extremely lengthy. Operators gave callers information on Child Health Plus if they specifically inquired about it, but callers sometimes were referred to specific plan numbers rather than the general Child Health Plus line, and one operator referred a caller to a nonworking Department of Health number. While the Human Resources Administration number is not toll free, the automated system is available 24 hours a day, 7 days a week, and makes information available in Spanish.

With the forthcoming joint application for Medicaid and Child Health Plus, it will be important to coordinate the existing hot lines and to train hot line staff on the reforms.

Implementation and Design Issues for New York

Collaborations will be important components of effective outreach, marketing, and application assistance initiatives in New York State. These collaborations may include traditional players in health care, as well as schools and nontraditional players such as religious institutions and employers. In addition, as New York State plans innovative strategies, methods should be piloted prior to full implementation, particularly with new and translated outreach materials. Furthermore, collaboration is most likely to succeed if players make substantial commitments of staff, funds, or other resources.

Outreach and marketing efforts in New York might be focused appropriately on children who are traditionally less likely to have insurance, including children of working parents, adolescents, foreign-born children or those whose parents are foreign born, speakers with limited use of English, children with special needs, and children who are racial or ethnic minorities.[10]

Effective advertising might de-emphasize the government's role in the programs and promote the private aspects, with which many applicants feel more comfortable. To address common misconceptions, ads may be explicit that children of working parents and those not receiving cash assistance may be eligible.[10] Advertising could also highlight the greater ease of the process for working parents. In addition, eligibility information can be described more effectively in terms of income levels in dollars, rather than the federal poverty level,[25] which denotes poverty and public assistance.

Shame and fear are commonly occurring themes around public programs. One mother in Brooklyn recommends peer-based outreach employing foreign-born mothers whose children are enrolled in Medicaid or Child Health Plus.[3]

Employing local mothers and grandmothers may be an effective strategy to overcome language and education barriers. This outreach could be conducted through home visits or in local settings such as churches, playgrounds, or beauty parlors.

Adolescents are frequently overlooked in outreach design. When marketing children's health insurance, "children" are often portrayed as only young children. Advertisements focus on childhood vaccinations with pictures of young children and logos written in the messy crayon writing of a first grader. Some states, in an attempt to distinguish their programs from stigmatized government programs, have renamed their programs Dr. Dynasaur, Cub Care, and KidCare. Focusing marketing strategies solely on the younger children may neglect the needs of adolescents. For teenagers in need of reproductive health care services, including contraception, abortion, sexually transmitted disease treatment, mental health care, drug and alcohol prevention, and violence prevention, a cartoon character is not an appropriate marketing tool.

Finally, well-designed outreach strategies that include application assistance will be a necessary, but not sufficient, component to increase enrollment of eligible children. Successful completion of an application and continued enrollment are likely to require a streamlined process, as discussed in the following section.

FACILITATING ENROLLMENT AND RECERTIFICATION

To meet current and enhanced enrollment objectives, outreach efforts are likely to require less information distribution and greater emphasis on enrollment-linked activities. It is helpful to think of different steps along a continuum: information distribution by the largest number of organizations to raise awareness about programs, followed by application assistance offered by a more limited group, funneling into facilitated enrollment provided by a limited number of organizations with more extensively trained workers. This section identifies selected enrollment and recertification strategies that are likely to be effective for New York State; in addition, it highlights potential implementation challenges.

Facilitating enrollment is required by the recent expansion in New York. The law provides that the health commissioner shall develop and implement locally tailored facilitated enrollment strategies targeted to children who may be eligible for benefits. Contracts for such activities may be granted to organizations, including child advocacy organizations, providers, school-based health centers, and local government.[26] Activities under the rubric of facilitated enrollment may include outstationing of Medicaid eligibility workers, authorizing nongovern-

mental entities to conduct the Medicaid face-to-face interview, presumptive eligibility, a combined Medicaid/SCHIP application form, shared eligibility with other public benefits programs, and a streamlining of the recertification process and requirements. Facilitated enrollment activities will be affected by the federal "screen-and-enroll" requirement, discussed in detail below. Additional activities that can improve the process include the option to submit an application or recertification by mail, simplifying and shortening forms, and translating materials into languages other than English.

The enrollment strategies discussed below will need to incorporate the new federal screen-and-enroll requirement. Principles underlying the federal SCHIP law are that coverage be extended to uninsured children and that SCHIP programs not supplant existing public or private coverage. To ensure that children are enrolled in the right program, HCFA requires that Medicaid-eligible children found through screening be enrolled in Medicaid rather than in a separate state health insurance program. States electing to expand SCHIP only through Medicaid are exempt from this requirement.

HCFA recommends the joint application forms as the simplest way to meet the screen-and-enroll requirement. In Oregon, state workers determine eligibility for both programs based on a joint application. Connecticut contracts with a private entity to review a joint application form, perform the initial Medicaid screen, and make the final eligibility determination for the non-Medicaid program. The contractor forwards the applications of children who appear to be Medicaid eligible to the Medicaid office for a final determination. Florida uses a similar model.

In New York, applicants for Child Health Plus will need to be screened for potential Medicaid eligibility and enrolled when appropriate. In response to concern that some families will opt to remain uninsured rather than enroll in Medicaid, HCFA has emphasized that Medicaid-eligible children are not eligible for the separate state child health insurance program despite their families' preferences. Implementation of the screen-and-enroll requirement will be adapted when the joint application form is adopted statewide. Enrolling children in the appropriate program raises a challenge for New York State; in April 1998, the New York State comptroller's office found that 41% of Child Health Plus enrollees were Medicaid eligible.[27] The state faces significant challenges in ensuring that children required to disenroll from Child Health Plus elect to enroll in Medicaid rather become uninsured. Additional difficulties may occur for children in central and upstate counties, where some managed-care plans participate in Child Health Plus, but not Medicaid.

Outstationing

In many states, including New York, Medicaid applicants generally have been required to appear in person at the Medicaid office for a face-to-face interview or to submit the application. Meeting this requirement may require parents to leave their places of employment for several hours or even take off work for an entire day because waiting times can last as long as 6 hours. The requirement to appear at the Medicaid office, sometimes on several occasions, poses an important barrier to enrollment for families. In addition to the difficulty in getting time off from work, families may also encounter difficulty in obtaining transportation, problems with arranging child care, and embarrassment in entering the office. A 1994 Children's Defense Fund (CDF) study shows that additional barriers include the lack of privacy during application interviews in the offices, crowded and unpleasant waiting rooms, and lack of bilingual staff.[28]

Outstationing of eligibility workers in a health care setting is a natural remedy for many of these barriers. The federal government requires states to allow pregnant women and children to apply for Medicaid at locations other than the Medicaid office. By allowing parents to apply for health insurance in a hospital or clinic during nonbusiness hours, parents are relieved of the burden of a trip to the Medicaid office. According to the National Governors' Association, 46 states propose outstationing of eligibility workers in their SCHIP plans.

According to Donna Cohen Ross of the Center for Budget and Policy Priorities, funding for outstationed workers is paid by federal funds and may include local private or public funds. Outstationed workers generally are employed by the state Medicaid agency, but may also include other state employees, such as deputized Title V Maternal and Child Health workers.[15] In 1990, Congress enacted legislation requiring states to place or fund eligibility workers at all federally qualified health centers (FQHCs) and disproportionate share hospitals (DSHs) and for states to fund outstationing adequately.[29] Outstationed workers can complete the entire application or recertification process with an applicant or recipient, including the face-to-face interview. Outstationing does not include the final determination of eligibility.

In addition to relieving parents of the burden of a trip to the Medicaid office, research has also indicated that outstationing is beneficial to providers because it reduces the level of uncompensated care.[30] A 1998 study by the Center for Health Policy Research, however, finds that 43% of FQHCs and DSHs responding to a survey did not engage in outstationed activities. Furthermore, only 62% of the centers conducting outstationing reported that they engage in all the mandated outstationing activities. The study finds that centers with more comprehensive

services were more likely to have greater financial and staffing resources. The centers report that lack of state funding for staff poses the greatest barrier to conducting their activities.

Additional challenges to outstationing include staff training. The US GAO studied a District of Columbia central Medicaid intake unit in 1993 and found that most Medicaid applications are denied not for failure to meet eligibility standards, but for procedural requirements. According to the GAO, Medicaid eligibility workers inform applicants of the necessary documentation and procedures, but often are not available for assistance in gathering the documentation. Applicants often do not understand how or where to obtain the necessary documentation. Documentation can pose significant problems, particularly for applicants who work off the books or who rent or sublet illegally.[31] Successful outstationing would include well-trained staff to assist applicants throughout the process.

Some states go beyond the federal mandate and conduct outstationing in locations other than DSHs and FQHCs. Georgia's Right from the Start Medicaid program requires its staff to spend at least 12 hours a week in a nontraditional outstationed setting such as a child care center, school, shopping mall, job site, church, or fast-food restaurant.[15] A resource coordinator at Right From the Start characterizes outstationing as very difficult work; workers typically work in three counties throughout the week. Mississippi has found that outstationing in a community health center shortens the application process because the worker devotes considerable time to applicants.[32] Rhode Island plans to hire outreach workers whose pay will be based in part on their success in enrolling children in RIteCare. California's Healthy Families legislation provides the opportunity to offer a one-time application assistance fee for organizations and individuals that help families enroll in the Healthy Families program or in MediCal. California already has used this strategy successfully in two other public assistance programs. The $50 assistance fee serves as an incentive to PTAs, WIC clinics, and county welfare departments to increase their activities in outreach and enrollment.

The recent New York expansion stipulates the outstationing of authorized workers in community settings accessible to large numbers of eligible children. These workers must be available during evening and weekend hours. The law authorizes outstationed workers to assist families in completing the application form, conduct the personal interview required for enrollment and recertification for Medicaid, and determine presumptive eligibility for Child Health Plus.[33]

Outstationing has been available for pregnant women applying for Medicaid

in New York State for many years. The Alan Guttmacher Institute reports that, in fiscal year 1991, 90.4% of New York women between the ages of 15 and 44 with incomes below 185% of the federal poverty level lived in a county where outstationing was available for pregnant women applying for Medicaid. While this is an impressively high number, outstationing is not implemented as broadly as it might be. A 1993 CDF study reveals that New York State had not implemented the law's minimum requirements pertaining to populations served, locations and hours, application forms and processing, low-use sites, and staffing.[34] In 1994, CDF highlighted four community-based outstationed centers in New York City: the Sunset Park Family Health Center, the William F. Ryan Community Health Center, the Bronx Perinatal Consortium, and the Alianza Dominicana.[35] These highly successful centers hire trained Medicaid eligibility specialists and outreach workers, many of whom live in the local area and are proficient in the patients' language. The sites provide assistance in a range of social service programs, during evenings and weekends, all at a low cost to the Medicaid program (approximately $25,000/year/staff member). They make a particular effort to inform patients about the expanded Medicaid eligibility levels, which is considered essential to effective outstationing.

Authorizing Nongovernmental Workers to Conduct the Medicaid Interview

Allowing nongovernmental workers to conduct the Medicaid interview is an important strategy to enhance access to Medicaid. Many hospitals and some community-based organizations are authorized to conduct the Medicaid interview at their facilities. For example, Mount Sinai Hospital's Resource Entitlement Advocacy Program (REAP) conducts the Medicaid interview and assists applicants and recipients in assembling the necessary documentation. It also submits the application package to the local Medicaid office for eligibility determination. REAP has a 99.9% Medicaid application approval rate, and HCFA has identified it as a model outreach program. In addition to Medicaid application assistance, REAP also assists clients in obtaining other benefits, including Child Health Plus, Medicare, Social Security Disability and Retirement, Supplemental Security Income, public assistance, and food stamps. By helping families secure benefits, REAP ensures that medical bills do not go unpaid.

Through a relationship with REAP, the Children's Aid Society also administers the Medicaid interview, enabling families to seek Medicaid without a visit to the Medicaid office. The Children's Aid Society conducts outreach to families in Washington Heights public schools, where there is a large immigrant population.

The outreach and enrollment worker does not wait for parents to approach her for help with child health insurance; rather, she reaches out to them as they drop off their children or pick them up from school. The work is labor intensive; according to the Children's Aid Society, walking parents through the application process can last as long as 6 hours.

Under a new program that will be piloted in New York City in 1999 by Statewide Youth Advocacy, day-care workers will be trained to help families apply for Child Health Plus and Medicaid using a joint Medicaid/Child Health Plus/WIC application and will be authorized to conduct the face-to-face interview required for Medicaid applications. Since many day-care workers themselves do not have insurance and may be eligible for Child Health Plus and Medicaid, this strategy includes a peer-based and streamlined approach that offers promise.

Another New York City pilot project under the auspices of the Washington Heights Child Vaccination Program Network will locate volunteers in community-based organizations to assist families in initiating the application process. Volunteer students will screen families for program eligibility, conduct outreach, provide application assistance using the joint application form, and conduct the face-to-face Medicaid interview. CDF staff will review the applications for quality assurance before sending them to the local Medicaid office for final eligibility determination. This is a collaborative of the CDF, Columbia University, Alianza Dominicana, and other agencies.

While outstationing and delegating nongovernmental organizations to conduct the interview provide valuable options to families applying for health insurance, rural areas with limited Department of Social Services staff may lack the resources to place outstationed workers in locations that would yield few applications. Additional concerns with outstationing include the decentralization of the application process. As application sites increase in a county, Medicaid offices may be concerned about losing control over the quality of the applications submitted. Adequate training should be sufficient to address such concerns.

Presumptive Eligibility

Presumptive eligibility is another method to facilitate enrollment of applicants into Medicaid and separate state programs. *Presumptive eligibility* refers to a preliminary determination made by a "qualified entity" that a child is eligible based on a declaration of family income without supporting documentation. During the presumptive period, providers are reimbursed for their services without regard to the final eligibility determination.

The Balanced Budget Act of 1997 authorized the use of presumptive eligibility

for children in the Medicaid program. Prior to this law, only pregnant women could be enrolled presumptively in Medicaid. Qualified entities for Medicaid include agencies or organizations that provide health care items or services, WIC, Head Start, and state or local agencies or not-for-profit groups that determine eligibility for subsidized child care under the Child Care and Development Block Grant.[36] Once the presumptive determination is made, Medicaid providers may receive payment for services rendered to children who are presumptively eligible regardless of the ultimate determination of the child's eligibility. The child's family must submit a full Medicaid application by the end of the following month. In states such as New York that continue to require a face-to-face interview for Medicaid, applicants must appear for an interview after the child is deemed presumptively eligible unless the entity making the presumptive eligibility determination is also qualified to conduct the face-to-face interview.

Presumptive eligibility is intended to improve access to timely health care, simplify the application process for families, and reimburse providers for services they provide to otherwise uninsured children. Presumptive eligibility is considered an effective tool for accelerating enrollment. A 1991 US GAO study found that states that had implemented presumptive eligibility and eliminated the Medicaid assets tests experienced the greatest increase in enrollment.[21]

One problem associated with presumptive eligibility is the failure of some applicants to follow through with the application process by submitting the necessary documents. Arkansas seeks to overcome this problem by providing assistance to applicants during the process.[21] Local health department staff use a document checklist with clients and help them with Medicaid procedures. Staff found that clients follow through more frequently with this assistance.

Another concern surrounding presumptive eligibility is the potential for ultimate denials and error rates. Error rates are based on the percentage of applicants that initially are considered Medicaid eligible, but ultimately are deemed ineligible due to income or other requirements. Recent guidance from the HCFA indicates that states adopting presumptive eligibility for children on Medicaid will not be affected adversely by sanctionable error rates. Data on error rates are not available widely. A 1993 study by the Alan Guttmacher Institute reveals that very few states monitor denial rates for presumptive eligibility for pregnant women.[37] According to Laura Cox, of the Center on Budget and Policy Priorities, four states that have monitored the number of pregnant women ultimately deemed eligible through presumptive eligibility find that between 75% and 84% of women are eligible.

Two distinct models of presumptive eligibility have been in place in New

York State for pregnant women and children through the Prenatal Care Assistance Program (PCAP) and Child Health Plus.

Under the PCAP model, pregnant women who go to a clinic for a pregnancy test or prenatal care may be presumed eligible for Medicaid based on the PCAP staff's initial review of the application. The presumptive period takes effect when the application is completed at the PCAP office and continues until the local Medicaid office makes a final determination of eligibility. In most cases, PCAP staff complete the application forms for the women, bring the applications and supporting documents to the Medicaid office, advocate on behalf of the women at the Medicaid office when necessary, and conduct the Medicaid interview at the clinic. Fewer supporting documents are required for PCAP than for regular Medicaid. In fiscal year 1991, 99.7% of women between the ages of 15 and 44 in New York State lived in a county in which presumptive eligibility existed for pregnant women, making New York a leader among the states in providing this option.[38] Presumptive eligibility is considered a critical component of PCAP's success in enrolling pregnant women whose income is below 185% of the federal poverty level.

When a child applying for Child Health Plus appears eligible based on an application that is submitted without full documentation, New York's Child Health Plus program provides for a 60-day period of presumptive eligibility. The period does not begin when the application is filed, but takes effect generally on the first day of the following month. However, depending on the plan and the date of application, enrollment may not take effect until the next month, which may be 45 days after applying. If supporting documents are not provided within 60 days, the child is disenrolled. No interview is necessary for an application for Child Health Plus. Under Child Health Plus, presumptive eligibility is not available during the recertification process.

While presumptive eligibility is an attractive option, some managed-care plans note the administrative difficulties of pursuing families for required documentation after the presumptive application is filed. Providing application assistance to families may reduce such problems.

Taking advantage of an option for states in the Balanced Budget Act of 1997, the expanded New York law authorizes presumptive eligibility for children applying for Medicaid. Until the provision takes effect, the law has an interim provision that allows children who appear eligible for Medicaid to receive presumptive eligibility through the Child Health Plus program. If "qualified entities" are authorized to conduct the face-to-face interview under the recent expansion, as in the PCAP model, families will encounter even fewer barriers to enrollment.

Linking Eligibility with Other Programs, Including "Adjunctive Eligibility"

Children can be reached through other programs for which they may be eligible. Many Medicaid-eligible children are also eligible for other government programs, such as free or reduced-price lunches, food stamps, Head Start, WIC, and Temporary Assistance for Needy Families. WIC and Medicaid have been linked historically in many states. Linking children to programs through *adjunctive eligibility*, which is the reliance of eligibility for one program to confer eligibility for another, is an effective method of increasing enrollment for children.

Computerized data sharing. At least nine states link eligibility data through computerized systems. According to the District of Columbia's Department of Human Services, applicants and recipients applying for a benefit are alerted to their eligibility for other benefits through a caseworker's use of a computerized system. The District of Columbia's system reduces the paperwork burden for both applicants and eligibility workers, while not replacing eligibility workers. In fact, workers must be well trained to use these systems. The process is substantially streamlined and allows automation for several tasks, including the printing of client notices and benefits cards.

Subsidized school lunch programs. Other initiatives that rely on eligibility data sharing include Florida's Healthy Start Program, which has adjunctive eligibility for Medicaid through the school lunch program; children eligible for the school lunch program are eligible automatically for Healthy Start.[39] A Chicago public school system is piloting a program that allows sharing of eligibility data between the school lunch program and Medicaid.

Other. Public schools in Massachusetts are working through school registration to ensure that students have health insurance. When parents register their children at school, they are asked if their children have health insurance. At some schools, parents with uninsured children are referred to an additional registration table that is staffed by a community worker who can assist with the application. At other Massachusetts schools, school nurses follow up with parents of uninsured children after the registration period, through either home visits or telephone calls. Tennessee examines its lists of food stamps beneficiaries to find those that are not enrolled in TennCare and sends those not enrolled a mail-in application and information hot line number. In Missouri, foster care children are specially linked with Medicaid; when children are registered initially with a foster care agency, they are screened and enrolled automatically for Medicaid if they are found eligible.[4] Colorado's Child Health Plan Plus (CHP+) links eligibility for

CHP+ to their indigent care program, free and reduced-price meals, commodity supplemental foods program, WIC, and health care for children with special needs. According to Colorado's plan, parents of these children will be able to apply for CHP+ with abbreviated forms; income verification will be derived from the state's other programs. Finally, President Clinton has proposed reaching out to uninsured children through their grandparents' participation in Medicare.[40]

The current Medicaid application in New York State, while lengthy, contains a voter registration form on the back page. It may be possible to coordinate further with the Board of Elections to provide information on Medicaid and Child Health Plus through other voter registration information channels. The state already coordinates outreach activities with the Department of Motor Vehicles, which has an existing relationship with the Board of Elections through the motor-voter registration program.

Recertification

Although a great deal of attention is focused on getting children initially enrolled in health insurance programs, there is generally less attention paid to the challenge of keeping eligible children enrolled. Children's loss of eligibility for a program because of a failure to recertify can result in a loss of continuity of care and unpaid medical bills.

Child Health Plus requires enrollees to recertify their eligibility every year. New York's child health expansion newly allows annual recertification for children on Medicaid, an improvement from the more frequent previous recertification requirements. The federal government's requirements for Medicaid recertification are minimal; they do not require a face-to-face interview or extensive documentation. Recent conversations with HCFA indicate that states simply may inquire if beneficiaries have experienced a change in financial status, residency, or other related eligibility factors.

Recertification requirements, like initial enrollment requirements, pose significant barriers to families. Traveling to the Medicaid office and navigating the bureaucracy remain difficult once a person is enrolled in a program. In reshaping the application process for Medicaid and Child Health Plus, it may be helpful to streamline the recertification process as well.

Summary of Key Issues in Facilitating Enrollment

The application process for Medicaid and, to a more limited degree, Child Health Plus, is perceived by many professionals and families to be formidable. Unclear or lengthy Medicaid applications, tedious documentation requirements, face-to-face Medicaid interviews—all pose barriers to enrollment. Experience to date in

New York and other states underscores the value of outstationing to assist in the application process. Creating an effective outstationing program, however, requires an allocation of staff and a commitment to training workers, along with a recognition that the process is time consuming. Moreover, as increasing numbers of non-Medicaid agencies are authorized to participate in the eligibility process, there may be a need to reaffirm links to that office. The enrollment process also can benefit from valuable programs, like presumptive eligibility and adjunctive eligibility, which have been shown to improve access to similar programs measurably. Application forms that are translated into other languages are a simple, but effective, means of facilitating enrollment for non-English speakers. New York's joint Medicaid/Child Health Plus/WIC application form offers promise, while simultaneously raising questions about its impact on immigrants and other populations. Finally, there is room to improve the recertification process for both Medicaid and Child Health Plus since it is another point in the continuum at which a high proportion of enrollees is lost to the system.

IMPROVING THE APPLICATION FORM

Designing an application form that is easy to use is an important step in improving access to insurance. Strategies include combining the Medicaid and separate SCHIP program applications into a joint form, allowing mail-in applications, and simplifying, shortening, and translating application forms into languages other than English. The following section addresses these methods of improving the application form.

Joint Application

The combined form is intended to simplify the application and recertification process for applicants, recipients, and staff. Joint applications can be particularly helpful for families who are uncertain about choosing the program to which they should apply. They may also help ensure that families who are denied Medicaid on the basis of their income are referred to the state's SCHIP program for consideration or vice versa. Combined application forms reduce paperwork for all parties.

Potential drawbacks to the combined application form include difficulties in coordinating the processing of applications among the county Medicaid office and managed-care plans or other entities responsible for processing applications to a separate state program. In addition, a joint application may cause a separate state program to suffer from the stigma that is sometimes associated with Medicaid, but rarely with separate state programs. Other concerns include the barriers immigrants may face with the combined application form. While Medicaid law

requires a social security number for applicants, many states' SCHIP programs do not require applicants to provide a social security number. Even if the application form indicates that a social security number is necessary only for Medicaid applicants, foreign-born parents may be deterred from applying due to fears of being reported to the Immigration and Naturalization Service. New York State law requires applicants for Child Health Plus to provide a social security number when available.

Since 1994, New York has used a one-page, Medicaid/WIC form for pregnant women and children. In fall 1998, the state began piloting a one-page, Medicaid/WIC/Child Health Plus form in select areas around the state. In addition to combining the three applications into one form, the form is considerably shorter and easier than the eight-page Medicaid application currently in use for all applicants except pregnant women and children. Families seeking additional benefits, however, such as cash assistance or food stamps, will continue to be required to use the more complicated, eight-page application form.

Mail-in Application Forms

Submitting an application through the mail reduces the burdens associated with a visit to the Medicaid office, including the need to take time off from work, find child care, and arrange transportation. Mail-in applications also reduce the potential stigma associated with applying for Medicaid in person.

As of July 1998, 27 states had the option of applications by mail for Medicaid, with no requirement for a face-to-face interview. Five of these states have a follow-up telephone interview once the application is received. One state SCHIP representative who had previously worked in the state Medicaid offices considers mail-in applications to be beneficial to both agency staff and applicants. Mail-in applications cut down on staff time and can be used to augment outstationing efforts. In Virginia, advocates worked with state officials to ensure that the application design is user friendly, to prevent applications from being filed incorrectly.

While New York State's Child Health Plus applications may be mailed to plans, Medicaid applications may not be mailed to the Department of Social Services. This is because New York State Medicaid law, which requires applicants to have an "interview," has been interpreted to require a personal or "face-to-face" interview. An alternate interpretation might permit a phone interview. With the new joint Child Health Plus/Medicaid/WIC application currently being piloted, applicants for Child Health Plus will maintain their existing mail-in option using the joint application. In contrast, Medicaid applicants will not be

able to mail this same application, although it can be submitted to authorized workers in the community.

Simplifying and Shortening Forms

Long and confusing application forms pose formidable barriers to enrollment. Twenty-nine states have shortened their Medicaid application form to be the same length or shorter than HCFA's model application. Simplifying the application form can reduce barriers to enrollment, which may result in better health outcomes. Georgia shortened its application form in 1993 and saw a 42% increase in enrollment among pregnant women and children, which lowered infant mortality and raised immunization rates. The HCFA recommends simplifying and shortening Medicaid application forms to 32 questions, which are confined to the applicant's name and address, family members' citizenship and health insurance status, and information on income and payments for child care. As discussed in the previous section on joint applications, New York's joint Medicaid/Child Health Plus/WIC form is considerably shorter and simpler than the original Medicaid form.

Applications and Information in Languages Other than English

Language barriers exist for many Medicaid and Child Health Plus applicants. To reach immigrant populations, some states have translated their applications and accompanying materials into other languages. Washington State has translated the Healthy Options booklet into Spanish, Russian, Vietnamese, Cambodian, Chinese, Korean, and Laotian. Oregon translates its printed application and Web page application into Spanish and produces applications in braille, large print, and audiotape.[15] California's MediCal and Healthy Families translates their applications and accompanying materials into Armenian, Cambodian, Cantonese, Farsi, Hmong, Laotian, Russian, Spanish, and Vietnamese. Fee-for-service Medicaid applicants in New York may receive application materials in Spanish. Some Child Health Plus plans offer information in Arabic, Chinese, French Creole, Hindi, Polish, Russian, and Urdu.

ELIMINATING INITIATIVES THAT UNDERMINE THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM ENROLLMENT MANDATE

Given the universal commitment at the federal, state, and local levels to enrolling uninsured children, the rationale for any conflicting initiatives should be revisited and revised when possible. For example, the climate created by welfare reform, with its emphasis on reducing the cash assistance rolls, has the potential to undermine the full enrollment objective of SCHIP. Families and Medicaid eligibil-

ity workers are exposed to different messages: while cash assistance is discouraged, enrollment in public health insurance for children is supposed to be encouraged. The resulting discord for those seeking benefits and for staff who administer them is problematic and appears likely to deter enrollment of children.

Another example can be found in a pilot program started in 1997 by New York City's Human Resources Administration. Called Eligibility Verification Review (EVR), the program includes home visits and interviews with neighbors of Medicaid applicants to combat Medicaid recipient fraud.[41] While Medicaid provider fraud is of concern in each state (the mandate for state Medicaid fraud control units is specifically to address provider fraud), there is little research on Medicaid beneficiary fraud, and there is no evidence of a problem with beneficiary fraud in New York City. New York City has pledged not to continue the initiative for children's applications, and other promising efforts are under way, including Medicaid outstationing at job centers and literature distribution on continued Medicaid eligibility for families not on welfare. Unfortunately, adding steps to the enrollment process at this time for any applicants may compromise the success of these outreach efforts.

Immigration is another area in which policies may be working at cross-purposes; immigrant families need to be assured that there will be no adverse consequences on their ability to remain in the US or to seek citizenship if they seek health coverage for their citizen or foreign-born children.

New York can maximize its chances of meeting new enrollment objectives by simplifying the messages sent to families and reinforcing whenever possible that health insurance is available for most families who cannot afford to buy it themselves. If local and state governments adopt policies that work at cross-purposes with the enrollment objectives of SCHIP and New York State's health insurance expansion, the resources and efforts committed to new outreach efforts may be wasted. Insuring a large percentage of eligible but uninsured children will require significant collaboration both within government and between the public and private sectors.

EVALUATION

Little research exists on the effectiveness of outreach methods for health insurance,[42] most likely due to the historically low level of funding for outreach, as well as the difficulty in measuring outreach efforts. In the University of Rochester's 1996 evaluation of Child Health Plus, one of the eight legislative objectives of the evaluation was to examine the effect of community-based and statewide outreach education efforts. They found it difficult to measure the effectiveness

of outreach activities because the linkage between Child Health Plus enrollment and marketing activities was weak. Therefore, one small, but useful, evaluation of marketing tools is to ask applicants how they were referred to Medicaid or Child Health Plus when they apply, either through the toll-free number, as New York's Growing Up Healthy does, or on the application form. Arizona and Illinois both have a space on their application forms to indicate how applicants heard of the programs. Tabulating the number of referrals achieved by each marketing method would allow the state to refine its advertising campaign better.

The New York State Department of Health conducts a variety of evaluation measures on both programs. The department collects data on enrollment and crowd out from each of the plans, as well as data on pediatric capacity. In addition, the department monitors the state's toll free hot lines to ensure that operators give correct information and that application materials are sent in a timely fashion.

Neil Halfon and colleagues[43] recommend evaluation measures, including retention and transition rates, that would examine the proportion of children continuously eligible for SCHIP who remain enrolled and the proportion of children who lose Medicaid eligibility who enroll in SCHIP. Other recommendations include the number of outreach workers per eligible individual or the number of language-competent workers per eligible individual.[42] The American Academy of Pediatrics recommends monitoring the percentage of children whose eligibility switches between Child Health Plus and Medicaid who enroll in the appropriate program.[44]

AREAS FOR FURTHER DISCUSSION

Based on this review of outreach, marketing, and enrollment strategies in New York and other states, several questions and issues emerge for further consideration.

Priorities. How will New York State and local communities set priorities for use of outreach funds? Are incentives needed to reward organizations that target the hardest-to-reach children?

Coordination. Who will coordinate the expanded number of outreach actors within each community to maximize their effectiveness from both consumer and organizational perspectives? Is this coordination function best undertaken by public or private agencies? How will organizations responsible for related, but distinct, activities along an outreach and enrollment continuum coordinate their

efforts? How will outreach for children's health insurance be coordinated with mandatory Medicaid managed-care enrollment?

Information sharing. How can New York benefit from lessons learned in pilot efforts both locally and nationwide? What vehicles for sharing information already exist, and are additional structures required?

Evaluation. How can plans for evaluation be incorporated into this significant expansion in outreach? Which outreach strategies are more amenable to evaluation?

Funding. How can organizations access public and private funds available for outreach efforts? What strategies should be used to inform the widest range of appropriate organizations about available funds?

Training. With the expansion of facilitated enrollment articulated in the New York law, what training will be needed to ensure the quality of applications completed at community sites? How will outreach organizations train their staff to shift from information distribution to application assistance or facilitated enrollment?

Joint Application. What impact will the joint Medicaid/Child Health Plus/WIC application have on enrollment of immigrant children? Will the stigma that sometimes is associated with Medicaid be transferred to Child Health Plus?

Continuity of care. How will New York comply with the federal screen-and-enroll requirement while maintaining continuity of care for Medicaid-eligible children?

Welfare reform. What strategies might address effectively the conflicting enrollment objectives of welfare reform and SCHIP?

ACKNOWLEDGEMENT

We acknowledge and thank the Foundation for Child Development for their support of this project and the roundtable participants and organizers who made this report possible.

REFERENCES

1. Selden TM, Banthin JS, Cohen JW. Medicaid's problem children: eligible but not enrolled. *Health Aff.* 1998;17(3):192–200.
2. United Hospital Fund. *Taking Steps, Losing Ground: the Challenge of New Yorkers Without Health Insurance.* New York: United Hospital Fund; September 1998.
3. American Academy of Pediatrics, Division of Health Policy Research. Analysis of

1998 March Demographic File, Current Population Survey and 1999 State Populations Projections by Single Year of Age, Sex, Race, and Hispanic Origin (Series A), United States Census Bureau, December 1997.

4. Newacheck PW. Health insurance and access to primary care for children. *N Engl J Med.* 1998;338(8):513–519.
5. US General Accounting Office. *Health Insurance: Coverage Leads to Increased Health Care Access for Children.* Washington, DC: US General Accounting Office; November 1997. HEHS-98–14.
6. Lave JR, Keane CR, Chyongchiou JL, Ricci EM, Amersbach G, LaVallee CP. Impact of a Children's Health Insurance Program on newly enrolled children. *JAMA.* 1998;270: 1820–1825.
7. S.7843/A.10767B.
8. Nelson K, Larsen K, Lurie N, et. al. Barriers to Medicaid enrollment in Minnesota: some implications for health system reform. *JAMA.* 1994;272(9):746.
9. Henry J. Kaiser Family Foundation. *Barriers to Medi-Cal Enrollment and Ideas for Improving Enrollment: Findings from Eight Focus Groups in California with Parents of Potentially Eligible Children.* Menlo Park, Calif: Henry J. Kaiser Family Foundation; September 1998.
10. US General Accounting Office. *Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies.* Washington, DC: US General Accounting Office; March 1998.
11. Ellwood MR, Leighton K. Welfare and immigration reforms: unintended side effects for Medicaid. *Health Aff (Millwood).* 1998;17(3):137–151.
12. Goodnough A. City to speed applications for welfare. *New York Times;* November 9, 1998, Section B, p. 1, col. 5.
13. Swarns RL. City ends plan to speed up welfare aid. *New York Times;* November 10, 1998, Section B, p. 1, col. 5.
14. Bureau of National Affairs. *HCFA, AHA Join DC Television Station to Launch Advertisement Campaign for CHIP. Health Care Policy Rep.* October 12, 1998.
15. Ross DC, Jacobson W. *Free and Low-Cost Health Insurance: Children You Know Are Missing Out. An Outreach Handbook.* Washington, DC: Center on Budget and Policy Priorities; 1998.
16. Maryland: CHIP program roars out of the blocks. *American Health Line.* November 30, 1998 (http://www.cloakroom.com/pubs/healthline).
17. Meyer JA, Bagby NS. Beyond enrollment: are SCHIP plans linking children to quality health care? *New Dir Policy.* May 1998;9.
18. National Governors' Association. *State Medicaid Coverage of Pregnant Women and Children.* Washington, DC: National Governors' Association; September 1997.
19. Naff R. Strategies to market health coverage and reduce barriers to enrollment. Paper presented at: *Covering More Kids: Outreach, Simplification and Coordination* national conference; Washington, DC; February 27, 1998.
20. McNamara P, Jellen BC. *Translating Entitlement into Access: Strategies and Examples for Hospital Leaders.* Chicago: American Hospital Association; 1993.
21. US General Accounting Office. *Prenatal Care: Early Success in Enrolling Women Made Eligible by Medicaid Expansions.* Washington, DC: US General Accounting Office; February 1991.Publication PEMD-91–10.
22. Colorado seeks foundation money for Kiddiecare outreach," *American Health Line.* August 19, 1998 (http://www.cloakroom.com/pubs/healthline).
23. Bureau of National Affairs. State officials try to boost enrollment in children's health insurance program. *Health Care Policy Rep.* October 12, 1998.
24. Dicker S. Permanent judicial commission on justice for children. Paper presented at: *Improving Young Children's Access to Health Care in New York City: the Role of Education and Human Service Programs;* NYU/New York Forum for Child Health Conference; September 24, 1998; New York.
25. Ross DC. Center on budget and policy priorities. Paper presented at: *Improving Young Children's Access to Health Care in New York City: the Role of Education and Human Service Programs;* NYU/New York Forum for Child Health Conference; September 24, 1998; New York.

26. S.7843/A.10767B.
27. State of New York, Office of the State Comptroller. *Department of Health, Management of Child Health Plus Program.* Albany, NY: Division of Management Audit and State Financial Services; April 1998. Report 97-S-10.
28. Children's Defense Fund/New York Child Health Project. *Medicaid Barriers: a Qualitative View of the Need for Change.* New York: Children's Defense Fund; January 1994.
29. Rosenbaum S, Maloy KA, Stuber J, Darnell J. *Initial Findings from a Nationwide Study of Outstationed Medicaid Enrollment Programs at Federally Qualified Health Centers: Implications for Low-Income Children Under Welfare Reform and CHIP.* Washington, DC: George Washington University Medical Center; February 1998.
30. US General Accounting Office. *District of Columbia: Barriers to Medicaid Enrollment Contribute to Hospital Uncompensated Care.* Washington, DC: US General Accounting Office; December 1992. Publication HRD-93–28.
31. Lieberman R. Paper presented at: *Improving Young Children's Access to Health Care in New York City: the Role of Education and Human Service Programs;* NYU/New York Forum for Child Health Conference; September 24, 1998; New York.
32. Carpenter MB, Kavanagh L. *Outreach to Children: Moving from Enrollment to Ensuring Access.* Arlington, Va: National Center for Education in Maternal and Child Health; March 1998.
33. S.7843/A.10767B.
34. Wessler J, Kane M, Rivera L, Rosenbaum S. *Outstationing of Medicaid Eligibility Workers in New York State: Is the Mandate Working?* New York: Children's Defense Fund/New York Child Health Project; March 1993.
35. Children's Defense Fund. *Ingredients and Cost of Outstationing: Four Model Community-Based Sites.* New York: Children's Defense Fund; December 1994.
36. Balanced Budget Act of 1997, P.L.105–33, Section 4912.
37. Frost JJ, Singh S, Gold RB, Martin A. *State Implementation of the Medicaid Eligibility Expansions for Pregnant Women.* New York: Alan Guttmacher Institute; 1993.
38. Gold RB, Singh S, Frost J. The Medicaid eligibility expansions for pregnant women: evaluating the strength of state implementation efforts. *Fam Plann Perspect.* 1993;25: 196–207.
39. US Department of Health and Human Services. *Report to the President: Interagency Task Force on Children's Health Insurance Outreach.* Washington, DC: US Department of Health and Human Services; June 1998.
40. Medicaid: president to unveil enrollment initiative. *American Health Line;* June 22, 1998 (http://www.cloakroom.com/pubs/healthline).
41. Bernstein N. New hurdle for some seeking Medicaid: home inspections. *New York Times;* September 20, 1998.
42. Carpenter MB, Kavanagh L. *Outreach to Children: Moving from Enrollment to Ensuring Access.* Arlington, Va: National Center for Education in Maternal and Child Health; March 1998.
43. Halfon N, Inkelas M, Newacheck PW. Enrollment in state child health insurance programs: strategies for evaluation and continuous quality improvement. *Millbank Quarterly.* In press.
44. American Academy of Pediatrics. *State Children's Health Insurance Program: Evaluation Tool.* Chicago: American Academy of Pediatrics; October 1998.